

NEIL ABERCROMBIE  
GOVERNOR



**STATE OF HAWAII**  
**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND**


P.O. BOX 2121  
HONOLULU, HAWAII 96805-2121  
Oahu (808) 586-7390  
Toll Free 1(800) 295-0089  
www.eutf.hawaii.gov

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**ADMINISTRATOR**  
BARBARA CORIELL

May 25, 2011

TO: COBRA Participants of the State and Counties

FROM: Barbara Coriell, EUTF Administrator 

SUBJECT: Adult Dependent Child Eligibility Extends up to Age 26 Effective July 1, 2011  
Limited Open Enrollment for this Event: May 27, 2011 to June 17, 2011

The Federal Health Care Reform legislation which extends the adult child eligibility up to age 26 for medical and prescription drug plans will be effective for COBRA plans on July 1, 2011. We are conducting a limited open enrollment from May 27, 2011 through June 17, 2011 only for COBRA participants who have newly **eligible** dependent children who are 19 but not yet 26 years old.

Who does this apply to:

- COBRA Participants who are eligible for EUTF medical and prescription drug plans who have adult children who are newly eligible who are not currently covered under the plan;
- Your children or your domestic partner's legal children by birth, marriage or adoption who are 19 but less than 26 years old as of July 1, 2011 and who are not eligible for coverage where they work;  
Adult children DO NOT need to be full time students;  
Adult children CAN BE married, working and living on their own;  
Adult children can be employed; HOWEVER, they cannot be enrolled in the COBRA plans if they are eligible for coverage where they work.

When:

- Is the open enrollment period? May 27 through June 17, 2011
- Does the coverage start? July 1, 2011, so long payment has been made on or before July 1, 2011

How: Submit the enclosed form no later than June 17, 2011:

Who:	Form:	To Whom:
Former employees EXCEPT Bargaining Unit 05/45	EUTF COBRA	Hawaii Employer-Union Health Benefits Trust Fund
Former employees with Bargaining Unit 05/45 enrolled in HSTA plans	HSTA COBRA	Attn: COBRA Unit P.O. Box 2121 Honolulu, HI 96805-2121

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The EUTF COBRA Election Form or HSTA COBRA Election Form is included with this memo.

The Questions and Answers below are provided to help you determine how this may affect you:

**Q1. Why is the EUTF allowing their COBRA Participants, participating in the Active plans, to add their adult children up to age 26?**

A1. It is required by the federal Patient Protection and Affordable Care Act (Health Care Reform), passed by Congress on March 23, 2010 and effective for employer plans at the beginning of their 1<sup>st</sup> plan year following September 23, 2010. For EUTF the effective date is July 1, 2011, so long that you made your payment by the first of the month and your COBRA benefits have not reached their expiration date.

**Q2. My adult child is working and able to get medical coverage through his job. Can I still add him on my plan?**

A2. No. If your adult dependent child is working and able to obtain medical coverage through his job, he is not eligible to enroll under your medical/prescription drug plans.

**Q3. Can my adult child drop his coverage where he/she works and be enrolled in the EUTF plan?**

A3. No, if your child is **eligible** for coverage where he/she works, he/she is not eligible for this plan

**Q4. What are the restrictions for adding my adult children up to age 26? Do they have to be full-time college students?**

A4. No, they do not have to be college students. Your adult children can join or remain on your plan whether or not they are married, living on their own, in school, financially dependent on you or not. The only exclusion is for adult children who are eligible to be covered by their employer's plan.

PLEASE NOTE: if your child is married, your child is eligible for coverage but the child's spouse and any of the child's dependent children are not eligible for coverage. Also, this does not apply to children for whom you only have legal guardianship.

**Q5. If my adult child is married or in a domestic partner relationship and/or has children, can my adult child's spouse or domestic partner and children be covered under my plan also?**

A5. No, only your adult child may be covered under your plan.

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**Q6. Can I enroll my domestic partner's adult child under the age of 26?**

A6. Yes. The same provisions listed above apply to your domestic partner's adult children.

**Q7. Can I enroll my adult child in the dental and vision plans?**

A7. No, the Affordable Care Act **only** requires that the opportunity is provided for the **medical and prescription drug plans** covering COBRA Participants in the active employer plans.

**Q8. Can I enroll my adult child and not be covered under the plan myself?**

A8. No.

**Q9. Can I make any other changes during this limited open enrollment period, such as change plans or enroll in a plan that I am not currently enrolled in?**

A9. No, you cannot change plans or enroll other family members just because you are now enrolling an adult child. However, if you are enrolled in Kaiser and your adult child lives in an area there is no Kaiser network, you may change your plan to HMSA or HMA.

**Q10. What will it cost for me to add my adult child?**

A10. If you are currently playing the "Self" rate, starting July 1, 2011 you will pay the "Two-Party" rate (unless you add two or more adult children, in which case you will pay the "Family" rate). If you are currently paying the "Two-Party" rate, you will pay for "Family" rate. If you are currently paying the "Family" rate, your premiums will not change. The rates can be found at EUTF's website at: <http://eutf.hawaii.gov>. Click on "COBRA Guidelines".

**Q11. Will the medical or prescription drug benefits be any different for my adult child than I currently receive?**

A11. No. The medical and prescription drug benefits will be the same; your adult child will be covered under the same plan.

**Q12. What if my adult child is being treated for a medical condition? Will charges for that treatment be excluded as a pre-existing condition?**

A12. No. There are no exclusions for pre-existing conditions under the plan. Coverage starts July 1 and applies to medical treatment received on July 1 and after.

**Q13. What do I need to do to enroll my adult child?**

A13. Please refer to the enrollment instructions above. Complete the revised May 2011 EUTF COBRA Election Form or HSTA COBRA Election Form included with this memo.

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**Q14. On the EUTF COBRA Election Form or HSTA COBRA Election Form, in Section 1 Employee Data, do I check the box “Open Enrollment”?**

A14. Yes. After completing the rest of the information in Section 1, skip to Section 3 Dependent Information and Plan Selections and check the “Add” box. Then fill in your adult child’s information. You must include your adult child’s Social Security Number – federal law requires that we request this. Then check the box “Medical” and/or “Drug”. Then sign and date Section 5: COBRA Participant Signature. Your adult child must enroll in the same medical and prescription drug plan that you are enrolled in.

Note: If you are not currently covered and are enrolling for yourself and your child, please complete the entire form.

**Q15. Will I get new membership cards for my adult child?**

A15. The following plans will send out new membership cards: HMA, Kaiser and HMSA HMO. The following plans will NOT send out new membership cards: HMSA PPO and informedRx.

**Q16. Will EUTF be having open enrollment informational meetings during this limited open enrollment?**

A16. No.

**Q17. If I do not complete a Continuation of Coverage COBRA Election Form during the limited COBRA open enrollment, will my health benefits terminate?**

A17. If you did not make payment directly to the carriers by the first of the month, your coverage will be terminated. If you did make payment by the first of the month, your COBRA health benefits will continue. You do **not** need to complete a COBRA Election Form to continue your current coverage.

**Q18. If I do not want to make changes, do I still need to complete a COBRA Enrollment Form?**

A18. No.

**Q19. Who can I contact if I have questions?**

A.19 We suggest you visit the EUTF website at <http://eutf.hawaii.gov> to see if the information you need is available there. Click on the following links that may be pertinent:

- New COBRA Guidelines
- Links to Carrier Web Sites

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If you still have questions, we prefer you email us your questions at: [eutf@hawaii.gov](mailto:eutf@hawaii.gov). In the subject line type: "URGENT – COBRA, Limited Open Enrollment". EUTF can answer your questions about eligibility, required supporting documents, and timing of submission of forms. However, if you have questions related to the **benefits** in any plan, we recommend you contact the applicable insurance carrier. Their contact information is:

- **ChiroPlan Hawaii, Inc.:**  
Honolulu (808) 621-4744, Neighbor Islands 1 (800) 414-8445  
711 Kilani Avenue, Suite 3, Wahiawa, HI 96786
- **Hawaii Dental Service (HDS):**  
(808) 529-9310, Toll-free 1 (866) 702-3883  
700 Bishop Street Suite 700, Honolulu, HI 96813
- **Health Management Associates (HMA):**  
(808) 954-8796, Toll-free 1 (866) 826-5335  
1440 Kapiolani Boulevard, Suite 1020, Attn: Enrollment, Honolulu, HI 96814
- **Hawaii Medical Services Association (HMSA):**  
Oahu (808) 948-6499, Toll-free 1 (800) 766-4672  
P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860
- **Kaiser Permanente (Kaiser):**  
(808) 432-5955, Toll-free 1 (800) 966-5955  
711 Kapiolani Boulevard, Honolulu, HI 96813
- **informedRx [billing handled by ARM Ltd.]:**  
Toll-free 1 (866) 533-6977  
ARM Ltd., 171 West Wing Street #210, Arlington Heights, IL 60005
- **Vision Service Plan (VSP):**  
Honolulu (808) 532-1600, Toll-free 1 (800) 522-5162  
P.O. Box 997100, Sacramento, CA 95899

Memorandum to COBRA Participants of the State and Counties

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The EUTF medical plans have been determined to be **Grandfathered Plans** under the Patient Protection and Affordable Act. A grandfather plan can preserve certain basic health coverage that was in effect when the law was enacted. This means that although most of the features of the Affordable Care Act apply to EUTF medical plans, some do not. For example, the elimination of lifetime benefit maximums will apply to our plans. However, providing coverage for preventive services with no member cost sharing does not. In addition, grandfathered plans may exclude those dependent children over age 19 who has access to medical coverage where they work. Grandfather status may change when changes are made to the plans. Should there be a change in Grandfather status, you will be notified.

Note: This memo and new questions and answers will be posted on EUTF's website as they arise.

**ATTACHMENT #1**  
**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND**  
**COBRA ACTIVE EMPLOYEES**  
**ALL BU'S EXCEPT BU12**  
**HSTA VEBA ACTIVE EMPLOYEES WHO OPT TO TRANSFER TO EUTF PLANS (BU05, 45)**  
**BU 05, 45 EMPLOYEES HIRED ON OR AFTER JANUARY 1, 2011**  
**EFFECTIVE MARCH 1, 2011**

<b>Benefit Plan</b>	<b>Type of Enrollment</b>	<b>Total COBRA Premium</b>
<b>MEDICAL &amp; PRESCRIPTION DRUG PLANS</b>		
EUTF PPO (HMA) – 90/10 Plan	Self	\$318.95
	Two-Party	\$774.85
	Family	\$988.79
EUTF PPO (HMSA) – 80/20 Plan	Self	\$308.53
	Two-Party	\$749.53
	Family	\$956.50
EUTF Prescription Drug (informedRx)	Self	\$72.23
	Two-Party	\$175.40
	Family	\$223.93
EUTF HMO (HMSA) Prescription Drug	Self	\$433.19
	Two-Party	\$1,052.25
	Family	\$1,342.81
Kaiser Comprehensive Prescription Drug	Self	\$384.58
	Two-Party	\$934.40
	Family	\$1,192.01
Kaiser Basic Prescription Drug	Self	\$324.73
	Two-Party	\$789.03
	Family	\$1,006.58
EUTF Supplemental (HMSA) informedRx Prescription Drug	Self	\$155.67
	Two-Party	\$378.64
	Family	\$483.34
Royal State Supplemental (effective 01/01/2011) Prescription Drug	Self	\$40.12
	Two-Party	\$100.30
	Family	\$111.63
EUTF High Deductible Health Plan (HMSA) Prescription Drug	Self	\$294.42
	Two-Party	\$715.53
	Family	\$913.20
<b>DENTAL PLAN</b>		
HDS Dental	Self	\$32.64
	Two-Party	\$65.24
	Family	\$107.51
<b>VISION PLAN</b>		
VSP Vision	Self	\$6.10
	Two-Party	\$11.28
	Family	\$14.74
<b>CHIROPRACTIC PLAN</b>		
RSN Chiropractic	Self	\$1.46
	Two-Party	\$2.93
	Family	\$3.10

**ATTACHMENT #2**  
**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND**  
**COBRA ACTIVE EMPLOYEES**  
**BU12**  
**EFFECTIVE MARCH 1, 2011**

Benefit Plan	Type of Enrollment	Total COBRA Premium
<b>MEDICAL &amp; PRESCRIPTION DRUG PLANS</b>		
EUTF PPO (HMA) – 90/10 Plan	Self	\$284.32
	Two-Party	\$711.65
	Family	\$923.26
EUTF PPO (HMSA) – 80/20 Plan	Self	\$275.06
	Two-Party	\$688.40
	Family	\$893.12
EUTF Prescription Drug (informedRx)	Self	\$48.90
	Two-Party	\$122.26
	Family	\$158.63
EUTF HMO (HMSA) Prescription Drug	Self	\$377.93
	Two-Party	\$945.95
	Family	\$1,227.20
Kaiser Comprehensive Prescription Drug	Self	\$316.49
	Two-Party	\$791.07
	Family	\$1,025.22
Kaiser Basic Prescription Drug	Self	\$267.28
	Two-Party	\$668.10
	Family	\$865.82
EUTF Supplemental (HMSA) informedRx Prescription Drug	Self	\$147.98
	Two-Party	\$373.32
	Family	\$491.76
Royal State Supplemental (effective 01/01/2011) Prescription Drug	Self	\$40.12
	Two-Party	\$100.30
	Family	\$111.63
EUTF High Deductible Health Plan (HMSA) Prescription Drug	Self	\$267.96
	Two-Party	\$671.61
	Family	\$872.90
<b>DENTAL PLAN</b>		
HDS Dental	Self	\$32.64
	Two-Party	\$65.24
	Family	\$107.51
<b>VISION PLAN</b>		
VSP Vision	Self	\$6.10
	Two-Party	\$11.28
	Family	\$14.74
<b>CHIROPRACTIC PLAN</b>		
RSN Chiropractic	Self	\$1.46
	Two-Party	\$2.93
	Family	\$3.10



EUTF <b>COBRA</b> MAY 2011	Hawaii Employer-Union Health Benefits Trust Fund <b>EUTF: COBRA ELECTION FORM</b>	PLEASE SUBMIT THIS EUTF COBRA ELECTION FORM TO THE EUTF
<b>SECTION 1: COBRA PARTICIPANT DATA</b>		Please complete all applicable fields below. Social Security numbers are required to process enrollments.

☐ Open Enrollment

☐ 2<sup>nd</sup> Qualifying Event

 COBRA Enrollee (Last Name, First Name, Middle Initial)
   
 \_\_\_\_\_

 Work Phone (\_\_\_\_\_) \_\_\_\_\_  
 Home Phone (\_\_\_\_\_) \_\_\_\_\_  
 Mobile Phone (\_\_\_\_\_) \_\_\_\_\_

 Gender ☐ Male ☐ Female  
 Birth Date: (MM/DD/YYYY)
   
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

COBRA Enrollee Residence Address

☐ Check this box if your address has changed

 Street \_\_\_\_\_  
 Line 2 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

COBRA Enrollee Mailing Address (if different from Mailing Residence Address)

☐ Check this box if your address has changed

 Street \_\_\_\_\_  
 Line 2 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**SECTION 2: COBRA PLAN SELECTION:**
☐ I (We) elect to continue coverage as indicated below and will be responsible for payment of the full cost of the selected coverage.

Medical Plan		<input type="checkbox"/> Cancel/Waive Medical Coverage	Choose only one box in each plan section		
Type	Carrier Selection		Self	2-Party	Family
PPO	PPO-Health Management Associates (HMA "90/10") No Drug Coverage		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PPO-Hawaii Medical Service Association (HMSA "80/20") No Drug Coverage		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	HMO-Hawaii Medical Services Association (HMSA) HMSA Drug Coverage Included		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO-Kaiser Basic Kaiser Drug Coverage Included		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO Kaiser Comprehensive Kaiser Drug Coverage Included		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HDHP	HDHP-High Deductible Health Plan (HMSA) HMSA Drug Coverage Included		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental	Supplemental-Hawaii Medical Service Association (HMSA) HMSA Drug Coverage Included		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Supplemental-Royal State National Insurance Company (RSN) InformedRx Supplemental Drug Included		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other Plans</b>		<b>Cancel/Waive</b>	<b>Self</b>	<b>2-Party</b>	<b>Family</b>
Prescription Drug	InformedRx Prescription Drug (not a valid selection w/the HMO, HDHP, or supplemental medical plans)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	Hawaii Dental Service (HDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	Vision Service Plan (VSP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic	ChiroPlan Hawaii, Inc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION 3: DEPENDENT INFORMATION AND ELECTION OF COBRA PLAN(S)**

List all eligible dependents you wish to cover. Relationship\* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MMDDYYYY)	Social Security Number	*Relationship	Gender M / F	Employed Yes / No	Medical	Drug	Dental	Vision
<input type="checkbox"/>	<input type="checkbox"/>		/ /					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Detailed eligibility information is available at [www.eutf.hawaii.gov](http://www.eutf.hawaii.gov) in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes.

Dependent Certification and Student Certification- See Section 4.6 and 4.7 of "Instructions for Completing Form EC-1" for more information.

I certify that all of my dependent children meet eligibility requirements for enrollment in the COBRA plans.

\_\_\_\_\_ (initials)

I certify that my dependent children, if employed, are not eligible for their employer's medical plan.

\_\_\_\_\_ (initials)

**SECTION 4: COBRA PAYMENT INFORMATION**

Checks are to be made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage and will not be reinstated. The monthly COBRA rates are subject to change in accordance with federal law.

<b>Health Management Associates (HMA):</b> (808) 954-8796, Toll-free 1 (866) 826-5335 1440 Kapiolani Boulevard, Suite 1020, Attn: Enrollment, Honolulu, HI 96814	<b>ChiroPlan Hawaii:</b> Honolulu (808) 621-4744, Neighbor Islands 1 (800) 414-8445 711 Kilani Avenue, Suite 3, Wahiawa, HI 96786
<b>Hawaii Medical Service Association (HMSA):</b> Oahu (808) 948-6499, Toll-free 1 (800) 766-4672 P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860	<b>Hawaii Dental Service (HDS):</b> (808) 529-9310, Toll-free 1 (866) 702-3883 700 Bishop Street Suite 700, Honolulu, HI 96813
<b>Kaiser Permanente (Kaiser):</b> (808) 432-5955, Toll-free 1 (800) 966-5955 711 Kapiolani Boulevard, Honolulu, HI 96813	<b>Vision Service Plan (VSP):</b> Honolulu (808) 532-1600, Toll-free 1 (800) 522-5162 P.O. Box 997100, Sacramento, CA 95899
<b>InformedRx [billing handled by ARM Ltd.]:</b> Toll-free: 1 (800) 533-6977 ARM Ltd., 171 West Wing Street #210, Arlington Heights, IL 60005	<b>Royal State National Insurance Company (RSN):</b> (808) 539-1600, Toll-free: 1 (800) 890-9022 819 S Beretania St, Honolulu, HI 96813

**SECTION 5: COBRA PARTICIPANT SIGNATURE**

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the "waive" box, it will be considered a "waive." I understand that the benefit elections made on this application are in effect for as long as I continue to meet COBRA's eligibility requirements, or until I elect to change them subject to the provisions of COBRA. I have read the benefit materials, understand the limitations and qualifications of the COBRA benefits program and agree to abide by the terms and conditions of the benefit plans selected.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for COBRA coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

COBRA Participant Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

If you do not submit this completed Election Form by the due date, you will lose your right to elect COBRA continuation coverage.

If you reject COBRA continuation coverage before the due date, you may change your mind as long as you finish this completed Election Form before the due date.